Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INJURY 1 TREATMENT CENTER
5931 DESCO DR
DALLAS TX 75225

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ASCENSION HEALTH

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-4934-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims are incorrectly denied. I was informed the treatment was denied due to a peer review. The EOB's state extent which is incorrect. The treatment performed, work hardening, was recommend [sic] by the patients treating doctor. [IE] meets the necessary requirements for the program."

Amount in Dispute: $9247.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider provided work hardening to the injured worker and submitted its medical bill utilizing the diagnosis code of 845.0 which identifies an ankle sprain. The carrier asserts that the documentation submitted by the provider establishes that it treated more than an ankle sprain. The date of injury is June 8, 2008 and it is not credible that the provider treated an ankle sprain March 26 through April 30, 2010… The work hardening program actually treated those conditions which are not part of the compensable right ankle sprain/strain despite the provider's utilization of the 845.0 diagnosis code."

Response Submitted by: Flahive, Ogden & Latson; P O Drawer 13367; Austin TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26 and April 9, 2010	97750-FC	$ 810.92	$810.92
March 29-31, 2010 April 1, 5-8, 2010 April 14, 16, 20- 23, 28- 30, 2010	97545-WH-CA	$2176.00	$2176.00
March 29-31, 2010 April 1, 5-8, 2010 April 14, 16, 20- 23, 28- 30, 2010	97546-WH-CA	$6261.00	$6261.00
		Total Due	$9247.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305 relates to MDR – General.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 3, 2010

   - 218 - Based on entitlements to benefits

   Explanation of benefits dated June 24, 2010

   - 219 – Based on extent of injury
   - 193 - Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. Is the disputed service eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.305 and §133.307?
2. Did the requestor treat the compensable right ankle sprain/strain?
3. Is the requestor entitled to reimbursement?

Findings

1. A Benefit Contested Case Hearing was held on December 8, 2009 and found that the compensable injury of June 8, 2008 does not include a peroneus longus split tear of the right ankle injury and depression. The parties agree that the compensable injury is a right ankle sprain/strain. Therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. The medical documentation submitted by the requestor in this dispute was reviewed. The requestor billed the disputed services for treatment of diagnosis code 845.0-anke sprain and strain. Therefore, the Division concludes that the disputed treatment was for the compensable injury. Documentation sufficiently supports treatment was rendered to the right ankle sprain/strain.
3. 28 Texas Administrative Code §134.204(g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. The Detailed Narrative Report was reviewed and it sufficiently supports the FCEs as billed. Therefore, the total allowable for the disputed FCEs is as follows:

   WC conversion factor $54.32 ÷ Medicare conversion factor $36.0791 x participating amount $28.87 = $43.466 per unit.

   On March 26, 2010, the requestor billed 14 units. The maximum allowable reimbursement (MAR) = $608.53; however the requestor is seeking $490.92, this amount is recommended.

   On April 9, 2010, the requestor billed 8 units. The MAR = $347.73; however, the requestor is seeking $320.00, this amount is recommended.

   28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR." A review of the requestor's medical bill finds that the requestor used modifier "CA" with CPT code 97545 and 97546.

   Texas Administrative Code §134.204(h)(3)(A) and (B) states "For Division purposes, Comprehensive Occupational Rehabilitation programs, as defined in the CARF manual, are considered Work Hardening.

   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

Therefore, the total allowable for the disputed work hardening program is as follows:

CPT 97545-WH-CA - $128.00 x 17 days = $2176.00

CPT 97546-WH-CA - $64.00 x 4 hrs = $256.00 Requestor is seeking $245.00, this amount is recommended.

CPT 97546-WH-CA - $64.00 x 5 hrs = $320.00

CPT 97546-WH-CA - $64.00 x 5.5 hrs = $352.00 x 2 days = $704.00

CPT 97546-WH-CA - $64.00 x 6 hrs = $384.00 x 13 days = $4992.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $9,247.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,247.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 16, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.